Workload Standardization Concept of Operations
Overview of Policy and Guidance for Operations during FY00

Purpose: This Workload Standardization document describes the process for transforming the measurement of Military Health System (MHS) medical treatment facility (MTF) workload from the existing systems to a re-engineered system for FY00. This process is an interim concept of operations to better represent the resources that are required to generate workload. In addition, through this process MHS workload measurement becomes quite similar to current best practices in industry. Since automation changes to fielded standardized systems are not feasible for implementation on 1 October 1999, this guidance requires no change in software in any of the related MHS systems: CHCS, ADS, CEIS, or MEPRS (EAS III). It does require minor changes or new entries in certain tables used by these systems that are normally and routinely updated prior to the start of each new fiscal year.

Scope: This document addresses only the highest priority shortcomings in the previous workload system, and defers both less urgent problems and more elegant solutions that would require software modifications. The deferred improvements occur in later phases that are to be implemented in subsequent fiscal years. For FY00, this guidance addresses only minor modifications to the way ADS and CHCS are used to capture MTF non-ancillary patient services. It does not require any modifications in the procedures used by other health care entities (e.g., Dental Clinics and Area Reference Laboratories) or in the recording of expenses into MEPRS.

Concept: Patient services, other than ancillary diagnostic work, are recorded concurrently with work performance. Discrete services, such as visits and extended visits (e.g., ambulatory procedure visits, observation cases), are recorded using the Ambulatory Data System (ADS). Continuous services (stays) are recorded using the Composite Health Care System (CHCS). Direct provider services are always viewed as discrete services, regardless of whether they are delivered as stand-alone visits or as a component of a stay. Workload for these services is separated into provider workload, consisting solely of the physician or most skilled provider's labor, and facility workload, consisting of all other materiel, labor, overhead, and supporting costs that are associated with the patient service. Provider workload is recorded by care setting which, for the short run, is identified and input using pseudo-provider codes in a secondary provider field of the ADS encounter form. Provider workload is tabulated in relative value units (RVU) based on the health care services as reported using Current Procedural Terminology (CPT) codes and HCFA Common Procedure Coding System (HCPCS II) and captured in ADS. Facility workload is tabulated according to setting. Hospitalized stays are tabulated in relative weighted products (RWPs) based on the diagnosis related group (DRG). Non-hospitalized stays are tabulated in RWPs based on the stay category and length of stay. These non-hospitalized stays do not meet InterQual standards for acute admissions, but include types of care similar to that found in skilled nursing facilities (SNF), hospice, or minimal care settings. Discrete services (including observation cases in the short-term) are tabulated in relative value units (RVUs) based on ambulatory patient groups (APG). In the short-term (FY00), workloads will be tabulated by the Health Program Analysis and Evaluation (HPA&E) office from the centrally collected encounter records generated by CHCS (Standard Inpatient Data Records, or SIDRs) and ADS (Standard Ambulatory Data Records, or SADRs). In the long term, ADS/CHCS will pass these tabulations to EAS and

generate WWR reports. For both long and short-term, provider labor should be allocated based on observed provider workload, and other facility costs allocated using facility workload, to obtain the best estimates of the costliness of the various healthcare encounters and services. In the short-term, this will be done centrally with no change in current automated systems. In the long-term, automated systems should be modified to accomplish this allocation.

The description that follows is organized into two broad categories: discrete services (visits) and stays. Within each category are sections describing the local actions needed to prepare the automation systems, identification and recording of the services, and the methods by which central (corporate) processing will tabulate workload. After the body of the document are two appendices and an attachment. Appendix A provides definitions of categories of care for non-hospitalized stays, case management, and self-care. Appendix B provides descriptions for the work centers that provide that care. The attachment provides excerpts of the newest UBU guidance as it relates to using ADS to capture workload.

Business Practices for Discrete Services

a. Preparing the Data Systems for FY00

(1) Updating the CHCS Provider Table

- Pseudo-Providers.

The SADRs from ADS will be "flagged" as special services by using artificial provider identifiers. To do this, pseudo-providers must be included in the CHCS provider table before an MTF can record a specialized discrete service, such as Home Health and Telemedicine. The new provider table entries should be:

Provider ID	Provider Name	Provider Specialty Type
000-00-0011	Home Health	600
000-00-0022	Telemedicine Consultant	600
000-00-0033	Telemedicine Initiator	600
000-00-0044	External Facility	600
000-00-0055	External Provider	600

These pseudo-providers are used to identify visits that satisfy the following definitions:

Home Health: A care provider visits a home to assess suitability of the environment for the provision of health care services or to provide care.

Telemedicine Consultant: A provider at one facility responds to a provider at a distant facility who requests documented consultation (non-ancillary diagnosis, prognosis, and/or treatment regimen guidance).

Telemedicine Initiator: A provider, co-located with the patient, requests and receives documented consultation (non-ancillary diagnosis, prognosis, and/or treatment regimen guidance) from a consultant at a distant facility.

External Facility: A DoD provider submits a SADR to his/her own ADS system reporting the rendering of health care services to a patient at a facility other than the one to which the provider is assigned. The provider was not on loan to that facility.

External Provider: A DoD provider completes two ADS Encounter Forms to report that he/she rendered health care services at a facility other than the one to which he/she is assigned. One ADS form is scanned at his/her assigned facility to capture the provider costs, and the second ADS form is scanned at the facility where services were performed to document institutional costs. The provider was not on loan to this facility.

- Omission of Unusable, Generic Providers – Currently, CHCS provider tables include a variety of "place holder" specialty types (e.g., "orthopedics") which do not identify a skill level. If these generic provider identifiers are present in the SADR output by ADS, the relative costliness of the actual provider cannot be known. Consequently, while generic provider descriptions can remain in the provider tables for use as "place holders," the ADS encounter forms (bubble sheets) must be updated to reflect the actual provider who performed the service. ADS will then automatically include on the SADR this provider's identifier together with the specialty type of the provider that includes skill level (e.g., orthopedic surgeon). If the primary provider on the bubble sheet is not updated, the workload cannot be credited.

(2) Attaching Providers to Clinics

Automated systems will not accept an appointment being made for a recorded provider who is not associated with a clinic/service. Before specialized discrete services can be appointed, (1) a conscious decision must be made by MTF management that a clinic/service will be authorized to perform specialized services (e.g., home health visits), and if so, (2) the clinic or service must be linked to the appropriate pseudo-provider in the provider table. However, this step is not required if the appointments will be scheduled for genuine providers rather than to the pseudo-provider type.

(3) Updating MEPRS Codes

New clinical/cost centers are required for FY00. Definitions for the following services and workcenters are provided in the Appendices.

MEPRS Code	Service Name
AZA	Hospice Care
AZB	Skilled Nursing Facility (SNF) Care
AZC	Minimal Care
AZD	Observation (will not be used in FY00)
AZX	Mixed Non-Hospital Stay Ward
FAR	Case Management
FAS	Self-Care

The Account Subset Definition (ASD) must be updated to include cost recognition and Stepdown Assignment Statistics (SAS) for these if they are to be used to capture costs as cost centers.

b. Identifying Recordable Discrete Services

Discrete services are recorded in ADS for most occasions when a provider-patient encounter occurs. This will normally include all services historically called "countable visits" and some that have not been considered "countable". Whether the patient is a hospi-

tal inpatient, non-hospitalized inpatient (hospice, SNF, or minimal care), or an outpatient does not affect whether the service should be recorded. Generally, a SADR should be created if a provider performs a patient service of sufficient substance that it should be documented in the patient record. Two exceptions are noteworthy: (1) Non-clinician and ancillary personnel working routinely in the patient setting and attending to patients staying in the work center of the personnel should not record routine services; and, (2) Provider groups (such as Grand Rounds for educational purposes) should not create any SADRs unless one member of the group takes an action sufficient to document the patient record (in which case only that provider would record the encounter). In addition, where provider contact is especially frequent or continuous (such as with some ICU patients), a single ADS form (bubble sheet) can be used during a period of time (not to exceed a day) to record each procedure (CPT code) performed by that provider. Guidelines for recording discrete services are illustrated in Figure 1 on the following page.

In recording these discrete services, all appropriate CPT and HCPCS codes will be used as they are defined for their intended purpose. For example, no restriction is placed on the E&M code 99211 limiting its use to non-physicians. Due to the limitations of ADS, however, one and only one E&M code may be recorded. The Unified Biostatistical Utility (UBU) group has recommended changes to ADS coding guidelines which address SADR generation and CPT code restrictions. Excerpts from these recommendations affecting workload standardization are attached to this document.

Figure 1. Guidelines for Reporting Discrete Services in ADS

Scenario	Description	# of ADS Forms Required	Complete ADS Form for Provider Workload at Provider Facility (Y/N)	Complete ADS Form for Institutional Workload at the Provider Facility (Y/N)	Complete ADS Form for Institutional Workload at the External Facility (Y/N)	Explanation [1]
1	A provider performs outpatient services at his/her assigned (or on loan to) DoD facility (including resource sharing and resource support)	1	YES	YES	N/A	The provider and institutional worklo lected by one ADS form scanned at th facility.
2	A provider performs inpatient services at his/her assigned (or on loan to) DoD facility (including resource sharing and resource support)	1	YES	NO	N/A	The provider workload is collected by form scanned at the assigned facility. T tional workload is captured by the DR SIDR.
3	A provider performs outpatient services at another DoD facility. The provider is not loaned labor to the external facility	2	YES	NO	YES	The provider workload is collected by form, using External *Facility*, scanned signed facility. The institutional workl lected by another ADS form, using *Ext vider*, scanned at the external facility. .
4	A provider performs inpatient services at another DoD facility. The provider is not loaned labor to the external facility.	1	YES	NO	NO	The provider workload is collected by form, using *External Facility*, scanned signed facility. The institutional worklo external facility is collected on the SIDI

[1] The fundamental principle is that provider workload will be attributed to the same "location" as the provider costs. If the prov salary expenses will show up at the receiving (DoD) facility, and that is where the SADR should be recorded/credited using th encounters. If part of the provider's normal responsibilities is providing care to his/her patients in a civilian setting, the salary e might be attributed to his/her assigned work-center. Since current policy guidance is to report salary expense in this case to an F-a show the same F-account. (If policy changed such that salary expense and workload should be reported to the B-code of the pro guidance would still be to record the SADR to the same cost center as the provider's cost, which would then be a B-code rather tha

Scenario	Description	# of ADS Forms Required	Complete ADS Form for Provider Workload at Provider Facility (Y/N)	Complete ADS Form for Institutional Workload at the Provider Facility (Y/N)	Complete ADS Form for Institutional Workload at the External Facility (Y/N)	Explanation [1]
5	A provider performs patient services (any kind) at a non-DoD facility. The provider is not loaned labor to the external facility.	1	YES	NO	NO	The provider workload is collected by form, using *External Facility*, scanned signed facility.
6	A provider initiates a request for Telemedicine consultation from a provider at another DoD facility	1	YES	YES	N/A	The initiating provider's (face-to-face tient) workload is collected by one A using *Telemedicine Initiator*, scanned signed facility.
7	A provider provides a consultation via Telemedicine	1	YES	NO	N/A	The consulting provider's workload is by one ADS form, *using Telemedicin ant*, scanned at the consultant's assigne
8	A provider performs a Home Health visit	1	YES	YES	N/A	The provider and institutional worklo lected by one ADS form, using *Hon* scanned at the assigned facility.

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c. Generating Encounter Templates (Appointing)

The ADS captures encounters primarily through the scanning of "bubble sheets". Administrative burden for providers is minimized when the forms are pre-printed and available at the time of the visit. For outpatients, this is routinely handled through the appointing process. For hospitalized and non-hospitalized inpatients, this may be facilitated in multiple ways. The preferred method for such inpatients is to use the "walk-in" functionality of ADS, which is the least burdensome administratively. Other alternatives include:

(1) Making daily appointments for each inpatient prior to the morning and leaving an encounter form in the inpatient record for use by the provider;
(2) Using any approved ADS automated front-end system (e.g., KG-ADS) to record the encounter on a terminal as it occurs;
(3) Scheduling a "walk-in" appointment in CHCS at the time of the encounter, then retrieving and using the encounter form generated; and,
(4) Using a blank ADS Encounter Form to record the patient, diagnosis, and procedure(s) for later transfer and recording by administrative personnel.

d. Recording Discrete Services

Every recordable discrete service must be recorded in ADS. In addition to the normal process of completing the forms, the following special instructions apply:

(1) Encounters for Inpatients (whether hospitalized or non-hospitalized stays)

- The encounter should be coded as "inpatient" by filling in the inpatient bubble.
- The work center (clinic) should be the service to which the provider is assigned and not the patient stay location.

(2) Use of CPT & HCPCS

- All applicable CPT codes should be recorded representing what occurred, regardless of whether the provider was a physician, and the codes should be used with their normal meaning as found in the CPT codebook references.
- Certain services should be recorded with the appropriate HCPCS Level II codes, especially if high cost or high volume. The table below identifies which HCPCS Level II codes are required and which are optional. The policy for recording is shown below. In the table, "Optional, High Cost" encourages recording if the cost of the item is over $200.

HCPCS Category		Coding Guidance
A	Transportation, etc.: 1. Ambulance 2. Medical/Surgical Supplies 3. Chiropractic	 1. Must record 2. Optional, high cost 3. Taken care of in CPTs
B	Enteral and Parenteral Supplies	Optional, high cost

HCPCS Category		Coding Guidance
D	Dental Procedures	Must record (inpatient cases only)
E	Durable Medical Equipment (DME, returnable)	Optional, high cost
G	Temporary Procedures for Professional Services	Omit
H	Rehabilitation Services	Omit
J	Drugs (Injections, Orals, and Chemo-therapy)	Record all clinic-provided drugs. Pharmacy-provided drugs are recorded in CHCS and should not be recorded in a SADR.
K	DME	Optional, high cost
L	Orthotic Procedures	Optional, high cost
M	Medical Services	Omit
P	Pathology/Laboratory	Out of scope. Use CPT codes.
Q	Miscellaneous Services	Optional, high cost
R	Radiology Services	Out of scope. Use CPT codes.
T	Surgical Services	Omit
V	Vision, Hearing, and Speech	Need to map to a CPT code for just the services.

(3) Specialized Visit Services

Specialized visit services (such as home health, telemedicine, and visits where the provider is not charged to the facility where the service is rendered) are flagged by recording the pseudo-provider identifier matching the visit circumstances. This pseudo-provider identity code is placed in the first secondary provider field. For consistency, "paraprofessional" should be selected as the role of this pseudo-provider. The identity of the actual provider is entered in the provider ID field. If more than one actual provider is involved, the additional provider's identity is entered in the second secondary provider field. If more than two providers are involved in a specialized visit service (an unlikely event), the primary provider is entered normally in the provider identity field, and the highest skilled of the additional providers is entered in the second secondary provider field.

e. Central Processing of Discrete Services

(1) Tabulations of Provider Workload

- The raw (provider) workload is measured for each SADR by converting each CPT code into its RVU equivalent and taking the sum of the largest RVU code plus 50% of all other RVU values in the SADR.

- Provider "costliness" is measured for each SADR by converting each provider type into its relative resource intensity using a scale similar to that shown below as an example, and summing the values. The actual scale is under development (in consultation with the MEPRS Management Improvement Group, MMIG) us-

ing salary expenses as reported in MEPRS. Generic provider specialty types that do not match a class (e.g., "orthopedics") are not included in the calculation.

Class of Provider	Relative Resource Intensity (Costliness)
Physician	1.0
Physician Extender	0.8
Nurse or Licensed Aide	0.6
Unlicensed Aide	0.4
Physician Resident	0.5

- The provider workload of the SADR is the product of the raw workload multiplied by the provider relative resource intensity. SADRs with provider workloads less than or equal to the workload equivalency of a physician assistant performing an intramuscular injection are not used in tabulating workload.
- Tabulations of provider workload for the organization are the sum of the SADR workloads for the time period desired.

(2) Tabulations of Facility Workload for Discrete Services:

- Each non-ancillary SADR (i.e., excluding MEPRS D codes) is grouped into its appropriate ambulatory patient group (APG).
- Each APG is converted into its relative weight.
- The medical APG and the E&M APG weights are combined.
- If the combined medical and E&M APG weight is less than any one of the procedural APG weights, it is dropped.
- The remaining APG weights are summed using 100% of the largest and 50% of any remaining APG weights. This sum is the facility workload for that SADR.
- Tabulations of facility workload for the work center or organization are the sum of the SADR workloads matching that center or organization for the time period desired.

Business Practices for Stays

a. Preparing the Data Systems for FY00

(Same preparation as for discrete services; need not be repeated)

b. Identifying Recordable Stays, and Types

(1) A stay should be recorded whenever a patient is assigned to a bed associated with any medical services and is not in observation status. Typically this will include the furnishing of a bed, linen, and a (shared) room at the expense of the facility (as defined in MEPRS), and may also include furnishing meals. This does not include housing people in "barracks" or non-facility housing.
(2) A patient who requires inpatient hospitalization should be admitted to the hospital. InterQual admission criteria must be used to determine appropriateness of hospital admissions.
(3) A patient who does not require acute hospitalization under InterQual criteria, but who stays at the facility as described above as recordable, must fall into one of the following categories. Detailed definitions of the categories are provided in Appendix A.

- Observation
- Skilled Nursing
- Hospice
- Minimal

c. Recording Stays

(1) All stays, other than observation, are to be recorded during FY00 using the "admission" processing of CHCS.
(2) Hospital inpatient admissions are not altered by this policy.
(3) Non-hospitalized inpatient admissions are admitted by the service describing the care (for example, AZA for hospice) to the ward where they are housed (for example, AZX for a mixed non-hospitalized ward, AAX for an internal medicine mixed ward).
(4) A patient who is transferred among work centers within an institution setting (within hospitalized stay wards or within non-hospitalized stay areas) can be recorded in CHCS as a transfer identically to the way hospital inpatients have been transferred between wards in the past.
(5) Transfers across institutional setting boundaries, whether a hospitalized inpatient switching to non-hospitalized or vice versa, require a discharge from the old setting and an admission to the new one in CHCS. Consequently, every SIDR will consist solely of hospitalized or non-hospitalized stays, never both types.
(6) Although the current local systems will count *hospital admissions* and *hospital bed days* and will assign DRGs to non-hospitalized stays, these should be removed from totals when accurate reflection of hospital workload is required.

d. Central Processing of Stays

(1) Hospital inpatient workload is tabulated based on DRG and using RWPs identically to past methods, except that any non-hospitalized stay inclusions should be excluded for most purposes.
(2) Non-hospitalized inpatient workload will be tabulated as *weighted days* of work, using a scale in which a typical skilled nursing day of care is 1.00, as shown in the example below (actual weights are still under development):

Non-Hospitalized Stay Category	Relative Resource Intensity
Skilled Nursing	1.00
Hospice	0.75
Minimal	0.50

(3) Work center or facility total workload is the sum of inpatient RWPs for hospital workload, and the sum of skilled nursing day equivalents for non-hospitalized stay workload based on the SIDRs of the period desired. For most purposes, SIDRs are assigned to the period of end-date-of-service, but for some purposes actual daily totals (partial SIDRs that span reporting periods) are more accurate.

Modifications to Third Party Collections

Manual interventions will be required in the short-term for non-hospitalized stays to avoid inappropriate billings.

Appendix A

Healthcare Service Definitions for Non-Hospitalized Stays

Hospice Services Provided within the MTF

The purpose of hospice care is to provide for the palliation or management of terminal illnesses and related conditions. The hospice service is available to individuals who have been certified by a physician to be terminally ill. An individual is considered to be terminally ill if he/she has a medical prognosis that his or her life expectancy is 6 months or less.

A plan of care must be established before services are provided and all services must comply with the plan of care. The following are included as hospice services: nursing care; medical social services; physician services; counseling services; medical appliances and supplies, including drugs and biologicals; and physical and occupational therapy. In general, the services must be related to the palliation or management of the patient's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

Skilled Nursing Facility Care Services Provided within the MTF

Skilled Nursing Facility (SNF) care is comprehensive institutional care designed for someone who has an illness, injury, or exacerbation of a disease process. It is goal oriented treatment rendered immediately after, or instead of, acute hospitalization to treat one or more specific active complex medical conditions or to administer one or more technically complex treatments, in the context of a person's underlying long term care condition and overall situations.

SNF care is for patients who (1) meet the InterQual criteria for admission to SNF, (2) require daily skilled nursing care or skilled rehabilitation services, plus other medical services, and (3) do not require frequent physician oversight. SNF care services include regular nursing care; meals, including special diets; physical, occupational, and speech therapy; drugs furnished by the facility; necessary medical supplies; and appliances.

Observation Services Provided within the MTF

Outpatient Observation Services are defined as those services furnished by a facility on the facility premises, including the use of a bed and periodic monitoring by a facility's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or to determine the need for a possible admission to a hospitalized stay as an inpatient or non-hospitalized stay such as SNF. Most observation services do not exceed 23 hours. However, in some instances, depending on medical necessity, up to 48 hours of observation services may be justified.

Minimal-Care Services Provided within the MTF

A physician will make a written determination to admit the minimal-care patient for services at the MTF. Self-care patients should not be admitted as minimal care (see definition of self-care).

Criteria are as follows:

1. Patients will not meet the InterQual criteria for admission to SNF;
2. Patients require some level of nursing care;
3. Patients require periodic physician evaluation; and
4. Patients require accommodation in an operating bed.

Examples:

1. Following receipt of acute care services, an Active Duty member with a severe burn to the hand requires daily nursing care and physical therapy for assessment of progress and resumption of full function.
2. A patient with an orthopedic injury requires monitoring and pain management for the first 72 hours following the injury.

Individuals who do not require any level of nursing care or physician evaluation, but who sleep in a bed located in the facility, would fall under Self-Care Services.

Self-Care Services Provided within the MTF

A physician, physician assistant, nurse practitioner, or other staff member as designated by the local MTF commander will make the determination to allow self-care patients or family members performing non-medical attendant functions to reside in the MTF overnight. Most MTFs currently have in place a holding unit for patients awaiting aeromedical evacuation and incorporation of those patients in the same self-care housing unit as the above beneficiaries is optional.

Criterion is as follows:

1. Nursing care or food delivery is not required.

Examples of self-care include:

1. Mothers breast feeding or bonding with hospitalized newborns.
2. Patients who do not have immediate access to medical care during their last phase of pregnancy (stork nesting).
3. Patients requiring diagnostic tests of an extensive nature or short-term rehabilitation services.
4. Family advocacy patients and/or family members who are the victims of abuse, neglect, or abandonment requiring placement pending disposition to home or as inpatients.
5. Soldiers returning from convalescent leave that are awaiting disposition.

Appendix B

Workcenter Definitions for Non-hospitalized Stay Locations

The following workcenter descriptions are provided for those MTFs that create a separate physical location for the specific non-hospitalized stay function, rather than simply using the corresponding MEPRS code to identify the non-hospitalized stay product. When the workcenter represents a physical location, hospitalized inpatients should not be commingled with the non-hospitalized stay cases.

Hospice Care Non-Hospitalized Stay AZA

This workcenter provides hospice care for the palliation or management of a terminal illness and related conditions. The following are included as hospice services: nursing care; medical social services; physician services; counseling services; medical appliances and supplies, including drugs and biologicals; and physical and occupational therapy. A physician must have certified that the individuals are terminally ill. An individual is considered to be terminally ill if he/she has a medical prognosis that his or her life expectancy is 6 months or less. A plan of care must be established before services are provided and all services must comply with the plan of care. In general, the services must be related to the palliation or management of the patient's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

Skilled Nursing Facility Care Non-Hospitalized Stay AZB

This workcenter provides skilled nursing facility (SNF) care during the active or convalescent stage of injury or illness. SNF care is comprehensive inpatient care designed for someone who has an illness, injury, or exacerbation of a disease process. It is goal oriented treatment rendered immediately after, or instead of, acute hospitalization to treat one or more specific active complex medical conditions or to administer one or more technically complex treatments, in the context of a person's underlying long term care condition and overall situations. Patients in the AZB workcenter do not meet InterQual standards for admission as acute care hospitalized inpatients.

Minimal Care Non-Hospitalized Stay AZC

This workcenter provides minimal services to patients who require some level of nursing care and periodic evaluation by a physician. The workcenter provides care and treatment to eligible patients who do not meet the InterQual criteria for admission to SNF.

Mixed Non-Hospitalized Stay AZX

This workcenter can provide any combination of the non-hospital stay services including hospice (AZA), SNF (AZB), or minimal (AZD) care services. This workcenter must meet all the standards prescribed for each of the non-hospital stay service types provided. Use this workcenter code when the volume of use is not sufficient to establish individual workcenters.

Case-Management Services FAR

This workcenter provides all case-management and related support services by nursing and other personnel in support of a patient's primary care manager not related to direct patient care for the patient during hospitalized or non-hospitalized stays or outpatient visits. Costs for case-management activities, disease management, and other population health management activities will be reported in this cost center. All costs will be stepped-down to appropriate final accounts on the basis of the number of cases managed.

Self-Care Service FAS

This workcenter does not provide any services beyond an overnight bed and is established to capture costs associated with housing of self-care patients or family members. A physician, physician assistant, nurse practitioner, or other staff member as designated by the local MTF commander, will make the determination to allow self-care patients or family members performing non-medical attendant functions to reside in the MTF overnight.

Attachment - UBU

UBU Recommendations for Changes to the ADS Coding Guidelines Which Address SADR Generation

The following are a subset of the UBU recommendations for changes to *ADS Coding Guidelines for Diagnosis and Procedure Coding* (May 30, 1997) which address specific services associated with SADR generation.

- Section 3.2 (Paragraph 1) *As a general rule, therapeutic services (including therapeutic ancillary services, such as radiation oncology) should report encounters using ADS encounter forms, while diagnostic services (e.g., lab, x-ray) that are already reported through CHCS are not.*

  The UBU recommends the following for this paragraph:

  Therapeutic services (including therapeutic ancillary services, such as hemodialysis, peritoneal dialysis, etc.) should report encounters using ADS encounter forms, while diagnostic services (e.g., lab, x-ray) that are already reported through CHCS, should not. In the case where ancillary services are performed and interpreted within a clinic, coding of an ADS Encounter Form is appropriate.

- Section 3.2 (Paragraph 2) *Encounters with inpatient and partial hospitalization patients occurring in clinics other than the admitting specialty will be reported using ADS. Inpatient encounters to ambulatory clinics of the admitting specialty are considered part of the inpatient stay and are not to be reported using ADS.*

  The UBU recommends deletion of this section from the coding guidelines.

- Section 3.2.1 *Full fracture care (i.e., evaluation, reduction, initial casting, and removal from the initial cast) will be coded using the appropriate orthopedic codes, 23500 – 28000. Casts that replace a previously applied cast, regardless of whether the cost was part of a global fracture care or simply a means of stabilization prior to fracture care, are coded using the application of casts and strapping codes, 29000 through 29750.*

  The UBU recommends the following wording for this paragraph:

  Full fracture care (i.e., evaluation, reduction, initial casting, and removal from the initial cast) will be coded using the appropriate orthopedic codes, 23500 – 28000. Casts that replace a previously applied cast, regardless of whether the cast was part of a global fracture care or simply a means of stabilization prior to fracture care, are coded using the application of casts and strapping codes, 29000 through 29750. A separate ADS Encounter Form is required for each encounter within these global services.

- Section 3.3 ADS *Encounter Summary Forms will be prepared for each day of partial hospitalization, as is done for outpatient surgery patients .*

The UBU recommends the following modification:

ADS *Encounter Summary Forms will be prepared for each day of partial hospitalization.*

- Section 4.1 *If the MTF pays the provider for the services from its operations and maintenance (O&M) account, then ADS documents the encounter and MEPRS determines the workload. If the provider is paid from Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)/ Managed Care Support Contract (MCSC) funds, the event is documented in CHAMPUS reports and an ADS encounter form is not appropriate.*

  The UBU recommends that this section be modified as follows.

  If a TRICARE/CHAMPUS provider performs services within the MTF, ADS should be used to capture the institutional workload using the External Provider pseudo-SSN designator. If the care is provided in an external facility, ADS should not be used to document any of the services.

- Section 4.2 *For military providers who are assigned to one facility but provide care at other locations, ADS will always be used to document the encounter in the clinic in which the care is provided. (The loaning facility records the provider's nonavailable time in MEPRS code FCD).*

  The UBU recommends modification to this section as follows.

  When a DoD provider is assigned to one facility and provides care in another DoD facility, two ADS Encounter Forms need to be completed. One ADS Encounter Form is coded using the External Provider Pseudo-SSN designator and is scanned in the ADS system at the facility where services were performed. The second ADS Encounter Form is coded using the External Facility Pseudo-SSN designator and is scanned into the ADS system at the provider's assigned facility.

  When a DoD provider is assigned to one facility and provides care in a non- DoD facility, one ADS Encounter Form needs to be completed. This ADS Encounter Form is coded using the External Facility Pseudo-SSN designator and is scanned into the ADS system at the provider's assigned facility.

- Section 4.4 *At this time, ADS only captures ambulatory data for fixed MTFs. It does not capture encounter information for providers in non-DHP (direct health program) owned and operated facilities (i.e., any service that is resourced by the Line).*

  The UBU recommends modification to this section as follows.

  ADS Encounter Summary Forms should be used to capture encounter information for medically-funded or privileged DoD providers in non-medically owned and operated DoD facilities (any service that is resourced by the Line).

UBU recommends the following additions to ADS coding guidelines which address SADR generation:

For recording provider workload for inpatient services, a general rule of one ADS Encounter Form per patient per day is appropriate. The provider will use the E&M codes to document the variability in acuity across patients and time. The following four methods are proposed to document rounds:

1. ADS Encounter Forms with *walk-in* for the *Appointment Type;*
2. Physicians input data into automated ADS applications;
3. Each day, using CHCS Patient Appointment Scheduling Module, preprint ADS Encounter Forms for appointed rounds and only amend records if rounds are not performed; or
4. Physician annotates record and clinic staffs generate appointment and complete ADS Encounter Form.

A second ADS Encounter Form may be used to document Grand Rounds, if a physician other than the attending physician conducted the rounds and documented care in the medical record.

Ancillary departments (i.e., laboratory, radiology, etc) should not generate SADRs; their services will be represented through the institutional workload and should not complete SADRs for inpatient care.

Those providers who are restricted to using E&M Code 99211 as the one and only applicable E&M code, will not complete ADS Encounter Forms for their inpatient services.

UBU Recommendations for Changes to the ADS Coding Guidelines Which Address CPT Coding Restrictions

The following are UBU recommendations for changes to *ADS Coding Guidelines for Diagnosis and Procedure Coding* (May 30, 1997) that address restrictions placed on the use of CPT codes by clinic personnel:

- Section 3.1 *Privileged Providers may use all E&M codes except 99211*.

  The UBU recommends that the restrictions placed on the use of 99211 by privileged providers be removed. All non-privileged providers are restricted to the use of 99211 or one of the three telephone consultation E&M Codes used by the advice nurses. There are a number of routine procedures (bandage replacement, blood pressure check, PAP smears, etc.,) that do not have any corresponding CPT codes and will only be collected as part of a more complex procedure performed by a provider.

- Section 3.1.4.3 *Privileged providers may choose from three E&M codes for telephone co nsults (i.e., 99371, 99372, and 99373). Non-privileged providers may also use all three tel e-*

phone consults as long as the SSN of a privileged provider is entered as a supervising pr o-vider in the additional provider block on the back of the ADS E ncounter Form.

UBU recommends the following wording for this section:

Privileged providers may choose from three E&M codes for telephone consults (i.e., 99371, 99372, and 99373). Non-privileged providers may also use all three telephone consults as long as the SSN of a privileged provider is entered as a supervising provider in the add i-tional provider block on the back of the ADS Encounter Form. Advice Nurses functioning under written and approved clinic protocol may complete an ADS Encounter Form for tel e-phone consults.

- Section 3.1.4.6 *E&M code 99499 will be used for APVs along with the APV bubble on the ADS Encounter Form on the date of procedure only. APVs are to be reported using an ADS Encounter Form for B**5 and C885 Ambulatory Procedure Units (APUs). Pre- and post-operative appointments will be documented as an encounter using an ADS form, but will not be denoted with the APV bubble. This is a departure from civilian practices that might i n-clude these visits under the concept of global care.*

  UBU recommends the following wording for this section:

  *E&M code 99499 will be used for APVs along with the APV bubble on the ADS Encounter Form on the date of procedure only. APVs are to be reported using an ADS Encounter Form for B**5 or C**5. Pre- and post- operative appointments will be documented as an e n-counter using an ADS form, but will not be denoted with the APV bubble. This is a departure from civilian practices that might include these vi sits under the concept of global care.*

- Section 3.2.3 *Although CPT provides separate E&M codes (92002, 92004, 92012, and 92014) for new and established ophthalmology patients, they are not to be used for ADS pu r-poses. The codes to be used are 99204, 99205, for new patients and 99214, 99215 for esta b-lished patients.*

  The UBU recommends that this restriction be removed and the codes 92002, 92004, 92012, and 92014 be applied for new and established ophthalmology patients.